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Methamphetamine

Background Information

Methamphetamine, a derivative of amphetamine, is a powerful stimulant that affects the central nervous system. Amphetamine was originally intended for use in nasal decongestants and bronchial inhalers and has limited medical applications, including the treatment of narcolepsy, weight control, and attention deficit disorder. Methamphetamine can be smoked, snorted, orally ingested, or injected. It is accessible in many different forms and may be identified by color, which ranges from white or yellow to darker colors such as red or brown. Methamphetamine comes in a powder form that resembles granulated crystals and in a rock form known as "ice," which is preferred by those who smoke methamphetamine. According to the National Institute on Drug Abuse (NIDA), users have been known to use cocaine, marijuana, morphine, and alcohol in combination with methamphetamine.

Methamphetamine is a Schedule II narcotic under the Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. If a person is convicted of trafficking methamphetamine, depending on the amount of methamphetamine and if a person was injured or killed during the crime, the trafficker can receive 5 to 20 years in prison and a fine not to exceed $10 million for the first offense. In addition to being a Schedule II drug itself, methamphetamine is made from chemicals that are regulated under the Comprehensive Methamphetamine Control Act of 1996. This act broadens controls on drugs such as ephedrine and pseudoephedrine, which are used in the manufacturing of methamphetamine. It also increases penalties for trafficking and possession of such chemicals without registration.

Effects

Methamphetamine use produces increases in energy and alertness and a decrease in appetite. An intense rush is felt, almost instantaneously, when a user smokes or injects methamphetamine. Snorting methamphetamine affects the user in approximately 5 minutes, whereas orally ingesting methamphetamine takes about 20 minutes for the user to feel the effects. The intense rush and high felt from methamphetamine results from the release of high levels of dopamine into the section of the brain that controls the feeling of pleasure. The effects of methamphetamine can last up to 12 hours. Side effects of methamphetamine use are convulsions, dangerously high body temperature, stroke, cardiac arrhythmia, stomach cramps, and shaking.

Long-term use of methamphetamine may result in addiction. Methamphetamine abuse can also cause violent behavior, anxiety, and insomnia, as well as psychotic behavior such as paranoia, hallucinations, mood swings, and delusions. The user can also develop a tolerance to the drug, which requires the user to take increasing amounts to induce the desired effects. Chronic users of methamphetamine are also characterized as having poor hygiene, a gaunt or pale complexion, and, at times, sores on their bodies from scratching at "crank bugs," which is a common delusion that bugs are crawling under their skin. Additionally, long-term use of methamphetamine can cause damage to the dopamine-producing cells of the brain.

Methamphetamine Use and User Characteristics

The statistical measures used to track drug use indicate that methamphetamine use is stable or rising. These studies show that the majority of methamphetamine

users are male, Caucasian, and over age 26. However, NIDA reports certain regions of the country exhibiting an increase in use among youth. The University of Michigan's *Monitoring the Future Study* reported that 5.3% of high school seniors from the class of 1998 had tried "ice" or crystal methamphetamine at least once in their life, up from 4.4% for the class of 1997. The study also found that 1.2% of seniors in the class of 1998 used "ice" in the past month, up from 0.8% in 1997. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 1.2% of the 12 to 17 age group used methamphetamine at least once in their life in 1997, up from 0.6% in 1996. SAMHSA also showed 2.5% of the U.S. population reported using methamphetamine in 1997, up from 2.3% in 1996 (table 1).

Table 1. Percentage reporting use of methamphetamine, at least once in lifetime, in the U.S. population aged 12 and over: 1994–1997

Year	12–17	18–25	26–34	35 and older	Total
1994	0.6	1.7	0.6	1.6	1.8
1995	0.8	1.9	3.8	2.1	2.2
1996	0.6	2.5	4.2	2.0	2.3
1997	1.2	2.3	2.7	2.6	2.5

Source: U.S. Department of Health and Human Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Preliminary Results from the 1995–1997 National Household Survey on Drug Abuse*, August 1996, July 1997, August 1998.

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) reports that there were 44,593 admissions to State-supported treatment facilities for methamphetamine abuse in 1995. Methamphetamine admissions made up 5.1% of all admissions, which was the fourth highest percentage after cocaine (38.3%), heroin (25.5%), and marijuana (19.1%). SAMHSA's Drug Abuse Warning Network (DAWN) reported 5,236 methamphetamine emergency department mentions in 1990; in 1994 the number peaked at 17,655 before dropping to 11,002 in 1996. DAWN also reported the number of methamphetamine-related deaths at 487 in 1996; the majority of the decedents were Caucasian males over the age of 26 (table 2).

Between 1990 and 1998, approximately 250,000 adult arrestees were tested for drug use through the National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) program. Table 3 shows the percentage of arrestees who tested positive for methamphetamine in selected cities and years. The cities on the West Coast (e.g., San Diego) had a much higher percentage of arrestees who tested positive compared with cities on the East Coast (e.g., New York or Philadelphia).

Table 2. Number of methamphetamine-related deaths* by gender, race/ethnicity, and age: 1992–1996

	1992	1993	1994	1995	1996
Total Mentions†	234	382	492	488	487
Gender					
Male	182	307	394	375	380
Female	50	71	97	94	94
Race/Ethnicity					
Caucasian	191	304	394	375	380
Black	12	21	26	24	20
Hispanic	22	43	59	75	68
Other	8	5	13	14	19
Age					
6–17	2	4	9	9	8
18–25	28	54	80	67	71
26–34	76	133	156	148	122
35 or older	127	190	243	258	280

* Excludes data on homicides, deaths in which AIDS was reported, and deaths in which "drug unknown" was the only substance mentioned.

† Includes episodes for which gender, race/ethnicity, and age were unknown or not reported.

Source: U.S. Department of Health and Human Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Drug Abuse Warning Network, Annual Medical Examiner Data 1992–1996*, 1994, 1995, 1996, May 1997, July 1998.

Table 3. Percentage of Arrestees Testing Positive for Methamphetamine, Selected Cities: 1990, 1994, 1997, and 1998

	1990		1994		1997		1998	
Site	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Atlanta	0.0%	0.0%	0.1%	0.3%	0.6%	0.7%	0.0%	—
Dallas	1.9	4.0	3.5	5.2	2.6	2.8	3.3	4.0
Denver	0.7	1.6	2.1	2.1	5.0	4.6	5.2	4.6
New York City	0.0	0.4	0.3	0.0	0.0	0.0	0.0	0.0
Omaha	0.6	—	3.3	2.7	9.7	13.3	10.2	13.6
Philadelphia	0.9	1.1	0.1	0.7	0.6	0.0	0.6	0.3
Phoenix	6.7	6.6	25.4	26.0	16.4	25.6	16.4	22.4
Portland	10.9	10.9	16.3	21.4	15.9	20.7	18.1	22.3
St. Louis	0.2	0.0	0.5	0.0	0.4	2.1	0.3	2.5
San Diego	27.3	31.8	41.0	53.0	39.6	42.2	33.2	33.3
San Jose	8.9	5.4	19.9	23.3	18.4	24.9	19.7	21.1
Washington, D.C.	0.1	0.6	0.1	0.0	0.3	0.0	0.0	0.5

Source: U.S. Department of Justice, National Institute of Justice, *1998 Annual Report on Methamphetamine Use Among Arrestees*, April 1999.

Availability, Production, and Trafficking of Methamphetamine

According to the U.S. Drug Enforcement Administration (DEA), methamphetamine production and trafficking are rampant in the West and Midwest areas of the United States, and increasing in the Southeast and

Northeast regions of the United States. In the Northeast, production and trafficking operations have increased and the principal traffickers are outlaw motorcycle gangs. The majority of methamphetamine was transported into the Northeast from outside sources. In the Southeast methamphetamine availability has increased significantly, and there has been an increase in seizures and investigations by law enforcement officials. The majority of the methamphetamine in this part of the United States was supplied from West Coast and Mexican drug-trafficking organizations rather than produced in the region.

The Midwest region has experienced a tremendous growth in methamphetamine trafficking and production, especially in portions of Iowa and Missouri. The main source of methamphetamine in the Midwest is Mexican-controlled trafficking organizations based in California and Mexico. There has also been an increase of clandestine laboratory production in the region. The West—especially California, Arizona, and Utah—continues to be the region in the United States with the most methamphetamine trafficking, production, and use. The majority of methamphetamine operations in this region are controlled by Mexican drug-trafficking organizations, based along the California-Arizona border. In the West, there is also a high rate of methamphetamine-related violence, including driveby shootings, murders, kidnappings, and assaults. This region also has the most clandestine laboratories in operation.

Law enforcement statistics for methamphetamine, such as drug seizure and arrest data, have increased in the United States. In fiscal year 1995, the DEA seized 958 kilograms of methamphetamine, which is the largest total amount seized by the DEA in 1 year. In the same year, the DEA also made nearly 2,700 arrests as a result of methamphetamine investigations; this is an increase of 23% over fiscal year 1994.

The price of methamphetamine is also on the rise. In 1995 a pound of methamphetamine ranged in price from $3,000 to $20,000. In 1997 the price for a pound increased from $3,500 to $30,000. An ounce of methamphetamine in 1997 cost from $400 to $2,800, and the cost of a gram ranged from $37 to $200.

Slang terms

Blue Mollies	Methlies Quick
Chalk	Mexican Crack
Crank	Quartz
Crystal	Shabu
Glass	Sketch
Go-Fast	Speed
Ice	Stove Top
LA Glass	West Coast
Meth	Yellow Bam

Clandestine Laboratories

Methamphetamine can be easily manufactured in clandestine laboratories (meth labs) using ingredients purchased in local stores. Over-the-counter cold medicines containing ephedrine or pseudoephedrine and other materials are "cooked" in meth labs to make methamphetamine. Manufacturing methamphetamine or "cooking" a batch releases toxic materials into the air as well as produces toxic waste after the drug is made. This situation can be very costly and dangerous for local authorities to deal with. As well as creating potential toxic waste dumps, meth labs have been known to be booby-trapped and lab operators are often well armed. Meth labs can be portable; they are easily dismantled, stored, or moved. This portability helps methamphetamine manufacturers avoid law enforcement authorities. Meth labs have been found in many different types of locations including apartments, hotel rooms, rented storage spaces, and trucks. The DEA and State and local law enforcement authorities seized 879 methamphetamine laboratories in 1996; this figure rose to 1,435 in 1997.

Summary

Available statistics show that production, trafficking, and use of the dangerous drug methamphetamine has increased, not only among the adult population, but also with the Nation's youth. Trafficking, production, and accessibility of methamphetamine have spread across the country, and have proved to be detrimental to the health of the Nation. Methamphetamine use can damage the user's brain and body, and production of the drug creates a hazard to law enforcement personnel, the community, and the producers of the drug. Increasing popularity and availability of methamphetamine, combined with the ease of manufacture and mobility of meth labs, present a costly and complex problem to Federal, State, and local authorities.

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